Ohio Department of Medicaid

ACCIDENT/INJURY INSURANCE INFORMATION

County	Unique Identifier	Case Name	Case Number

Section I

Complete when accident of injury has occurred

Names of Case Member(s) Injured	Date of Birth	Medicaid Billing Number	Social Security Numbers (s)

Place where Accident Occurred

Date of Accident/Injury	☐ Work ☐ Auto ☐ Home ☐ Others ☐ Specify
Was there another party at fault?	Are you making a claim against the other party
Explain the circumstance and describe the injuries	
If you are represented by an attorney, give name	Name and address of your insurance company
Attorney address and phone number	Insurance Policy I.D. number and/or Group#
Have you made a claim for or received a settlement or other benefits? ☐ Yes ☐ No	
If Injury occurred at work, was it reported to employer ☐ Yes ☐ No	If claim was made for Workers Compensation benefits, give claim number
Name, Address and Phone of Injured Person's Employer(s)	

SECTION II

I acknowledge that I have read this Questionnaire, or that it was read to me, and that I understand its purpose and effect, and that it is a true and correct statement to the best of my knowledge and belief.

Signature of Recipient or Guardian	Date
Signature of Witness	Date
Address	Telephone Number

Distribution: Original to Ohio Department of Medicaid
TPL Section
P.O. Box 182410
Columbus, Ohio 43218-2410

Provide one copy to the recipient. If the IV-D Section originates the form, they should retain one copy and forward the other to IV-A. If IV-A originates the form, send one copy.